

# SETTLED BENEFIT SUMMARY

## JULY 1, 2020

BENEFIT	CITY OF WORCESTER DIRECT	CITY OF WORCESTER ADVANTAGE	BCBS NETWORK BLUE NEW ENGLAND	BCBS BLUE CARE ELECT PREFERRED (Those Residing out of New England only)	
				In Network	Out of Network
Deductible	\$400 Ind/\$800 Fam	\$500 Ind/\$1,000 Fam	\$500 Ind/\$1,000 Fam T2 & T3 Only	\$500 Ind/\$1,000 Fam	
Out of Pocket Maximum	\$4,000 Ind/\$8,000 Fam – Med \$1,500 Ind/\$3,000 Fam – Rx	\$4,000 Ind/\$8,000 Fam – Med \$1,500 Ind/\$3,000 Fam – Rx	\$4,000 Ind/\$8,000 Fam – Med \$1,500 Ind/\$3,000 Fam – Rx	\$4,000 Ind/\$8,000 Fam – Med \$1,500 Ind/\$3,000 Fam – Rx	
Wellness Visit	\$0	\$0	\$0	\$0	20% co-insurance after deductible
PCP Office Visit	\$20	T1: \$20   T2/T3: \$25	T1: \$20    T2: \$30    T3: \$40	\$40	20 % co-insurance after deductible
Specialist Visit	\$30	T1: \$30   T2/T3: \$35	\$40	\$40	20% co-insurance after deductible
Prescriptions	Retail = \$10/\$25/\$50 30-Day Supply **Mail-away = \$20/\$50/\$150 90-Day Supply	Retail = \$10/\$25/\$50 30-Day Supply **Mail-away = \$20/\$50/\$150 90-Day Supply	Retail = \$10/\$25/\$50 30-Day Supply **Mail-away = \$20/\$50/\$150 90-Day Supply	Retail = \$10/\$25/\$50 30-Day Supply **Mail-away = \$20/\$50/\$150 90-Day Supply	
Inpatient Hospital	\$200 after deductible	T1: \$250   T2/T3: \$500 after deductible	T1: \$150    T2: \$150    T3: \$500 T2 & T3 after deductible	10% co-insurance after deductible	30% co-insurance after deductible
Outpatient Surgery	\$100 after deductible	T1: \$150   T2/T3: \$300 after deductible	Surgical day care facility – T1: \$150    T2: \$150    T3: \$500 Ambulatory surgical facility - \$150 T1: 0 deductible T2 & T3: after deductible	Office setting \$35 Ambulatory surgical facility \$300 per admits	20% co-insurance after deductible
Diagnostic Services Lab, X-ray, etc.	Covered in full (after deductible)	Covered in full (after deductible)	T1: \$0    T2: \$0    T3: \$0 (T2 & T3 after deductible)	10% co-insurance after deductible	30% co-insurance after deductible
CT scans, MRIs, PET scans	\$50 (non-hospital setting) or \$100 (hospital setting) for MRIs, PET, and CAT scans after deductible	\$50 (non-hospital setting) or \$100 (hospital setting) for MRIs, PET, and CAT scans after deductible	T1: \$50 per category, per date of service T2: \$50 per category, per date of service T3: \$450 per category, per date of service	10% co-insurance after deductible	30% co-insurance after deductible
Short-term Rehab: Outpatient, OT, PT	\$20 co-pay (after deductible) 60 visits per plan year	\$25 co-pay (after deductible) 60 visits per plan year	\$40 per visit 60 visits per calendar year	\$40 per visit (up to 100 visits per calendar year)	20% co-insurance after deductible (up to 100 visits per calendar year)
Skilled Nursing	Covered in full Up to 100 days per plan year after deductible	Covered in full Up to 100 days per plan year after deductible	Covered in full (Up to 100 days per Calendar Year)	10% co-insurance after deductible (Up to 100 days per Calendar Year_	30% co-insurance after deductible (Up to 100 days per Calendar Year)
Chiropractor	\$20 per visit (up to 12 visits per plan year)	\$25 per visit (up to 12 visits per plan year)	\$40 per visit	\$40 per visit	20% co-insurance after deductible
Outpatient Mental Health	\$20 per visit	\$20 per visit	\$20 per visit	\$40 per visit	20% co-insurance after deductible
Durable Medical Equipment (wheelchairs, crutches, etc.)	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance	20% co-insurance	40% co-insurance after deductible
ER Visit (Waived if Admitted)	\$100	\$100	\$100	\$150	\$150
Ambulance	Covered in full if medically necessary or when ordered by a physician after deductible	Covered in full if medically necessary or when ordered by a physician after deductible	Covered in full if medically necessary or when ordered by a physician no deductible	Emergency: 10% co- insurance - no deductible. Medically necessary: 10% co-insurance after deductible	Emergency: 10% co- insurance - no deductible Medically necessary: 30% co-insurance after deductible
<b>PREMIUM RATES</b> Monthly (IND/FAM) <b>Employee Cost</b> Weekly (IND/FAM) Monthly (IND/FAM)	\$645.64 / \$1,640.48  \$37.25/ \$94.64 \$161.41 / \$410.12	\$806.48 / \$2,002.36  \$46.53 / \$115.52 \$201.62 / \$500.59	\$980.07 / \$2,533.84  \$56.54 / \$146.18 \$245.02 / \$633.46	\$1,049.20 / \$2,712.89  \$60.53 / \$156.51 \$262.30 / \$678.22	

\*This is a brief summary of some of the benefits offered. Additional details can be found in the complete plan descriptions.

\*\*Mandatory mail-away for maintenance drugs, or 90-day at retail for maintenance drugs; however, only allowed at CVS pharmacies.